Testimony to the Little Hoover Commission
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Funding and Financing of California's Alcohol/Drug Treatment System: Issues for System Efficiency, Access, Management, Coordination and Improvement

Demand for Alcohol and Drug Treatment Services in California and the United States

California's population has grown to approximately 35 million people and, like every population, contains a large number of individuals who acknowledge their drug and/or alcohol problems and obtain treatment for them. Still others seek treatment but cannot obtain it because demand exceeds supply. Some individuals remain untreated and cost the state, their families and themselves millions of dollars in avoidable costs such as emergency and acute medical care, criminal justice system and court costs, highway accidents, community and domestic violence, incarceration, lowered productivity and premature ageing and early mortality. While the demand for treatment is high as are the costs of providing treatment, the costs of untreated substance abuse may be even greater.

California's Demand for Treatment

The National Association of State Alcohol and Drug Directors (NASADAD) recently published a study from which some tables are useful in showing how many Californians were admitted to the specialty alcohol and drug treatment system funded by the state, compared to the numbers admitted in other states. The 2000 study was based on the latest available comparative data (1998) reported by the states.

Table 1 below shows that 197, 657 individuals in California were admitted to treatment in 1998, more than 11% of the national total and more than any other state. In addition, while California had many admissions for alcohol treatment (48,633 reported), its alcohol treatment rates were less than the national average, but its drug and methadone treatment populations were the largest in the U.S. and substantially more than other large states such as New York, Illinois and Massachusetts. California had more individuals in methadone treatment in 1998 than any other state in the country by a huge margin: 59,853 people in California, over half the national total, compared to 10,887 in New York, the state with the second highest number.

TABLE 1

Alcohol and Other Drug Client Treatment Admissions For Fiscal Year 1998[i]

State	Alcohol	Drug	Methadone*	TOTAL
Alabama	7,795	11,105	515	18,900
Alaska	6,157	1,575	140	7,732
Arizona	19,061	19,661	0	38,722
Arkansas	6,917	7,384	114	14,301
California	48,633	149,024	59,853	197,657
Colorado	51,262	11,863	0	63,125
Connecticut	17,341	25,339	7,067	42,680
Delaware	2,069	4,101	0	6,170
Florida	20,473	42,078	913	62,551
Georgia	6,504	6,687	0	13,191
Hawaii	2,237	3,498	0	5,735
Illinois	48,265	84,940	7,966	133,205
Indiana	11,283	7,046	586	18,329
Iowa	13,227	11,561	58	24,788
Kansas	6,770	6,274	0	13,044
Kentucky	5,590	4,468	146	10,058
Louisiana	9,919	16,891	0	26,810
Maine	7,260	2,286	306	9,546
Maryland	11,672	14,716	2,379	26,388
Massachusetts	43,520	49,527	5,896	93,047
Michigan	45,814	41,272	3,008	87,086

Mississippi	10,802	9,581	0	20,383
Missouri	17,383	19,675	360	37,058
Nebraska	6,366	2,543	0	8,909
Nevada	3,795	5,017	681	8,812
New Hampshire	4,254	2,508	2	6,762
New Jersey	15,866	31,314	7,581	47,180
New Mexico	12,013	4,239	958	16,252
New York	71,629	62,083	10,887	133,712
North Carolina	24,630	20,990	0	45,620
North Dakota	2,126	656	0	2,782
Ohio	48,561	46,660	21	95,221
Oklahoma	7,540	6,420	134	13,960
Oregon	33,717	29,310	3,392	63,027
Pennsylvania	30,336	32,895	669	63,231
Rhode Island	4,463	6,713	1,637	11,176
South Carolina	17,268	10,560	99	27,828
South Dakota	10,516	3,567	0	14,083
Tennessee	5,802	7,355	0	13,157
Texas	12,301	24,419	1,284	36,720
Utah	7,167	9,452	340	16,619
Vermont	4,615	1,889	0	6,504
Virginia	26,181	42,378	1,948	68,559
Washington	28,471	27,386	1,777	55,857
West Virginia	14,875	3,979	0	18,854
Wisconsin	34,793	7,278	250	42,071
TOTAL	847,239	940,163	120,967	1,787,402

% of Total	47%	53%		100%

Underestimated Demand

While the numbers in Table 1 are certainly large and significant, they are now four years old and the totals by state have probably increased as the population has grown, both nationally and in California. In addition, as noted above, many individuals who seek treatment are discouraged from receiving it because demand far exceeds availability. Almost every county in the state has long waiting lists of Californians who want to be treated for alcohol and drug problems. Unknown numbers of other Californians drop off the waiting lists due to continued drug and alcohol dependence and lack of treatment supply. And still others never seek treatment in the first place after they hear about the long waiting lists. Therefore, what you see above is only the observed demand. The DADP estimated in a recent LAO report that twice as many Californians seek treatment as are able to receive it. So, while the numbers above are impressive, they are an understatement and they represent only those who were admitted to the specialized alcohol and drug treatment programs reported by this state.

State-Funded Care in General Hospitals

Another large number of individuals seek treatment for alcohol and drug problems from inpatient general hospitals, where many of them are admitted via the emergency room when their health has significantly deteriorated. Table 2 below shows that in 1997 almost 40,000 additional individuals received inpatient care with a primary diagnosis of substance abuse (many others had substance abuse as a secondary diagnosis). Many of these individuals may have been admitted for services for substance abuse/overdose (politely called "alcohol or drug poisoning"), for emergency services due to intoxication, or for detoxification. In each case, the services have a high attached cost because they were considered inpatient services, with high costs. As you can see from Table 2, some of these individuals had private coverage but many admissions were paid for by state, local and federal funds.

This mix of payors for inpatient care is typical and also represents one of the major complexities facing the California ADP agency: managing a mix of payors for state services goes with the job, which is not an easy task. This payor mix focuses only on general hospital inpatient care, not on specialized inpatient care or residential/outpatient care in the specialty treatment sector. Nevertheless, the point is important: managing the mix of varying payors who contribute to the payment of California's alcohol and drug treatment system is an inescapable and often complex task.

Table 2

EXPECTED SOURCE OF PAYMENT	NUMBER OF DISCHARGES – SUBSTANCE ABUSE	
	Number	Percent
Medi-Cal	2,837	7.2%

Medicare	6,746	17.1%
Other	300	0.1%
Other Government	6,585	16.7%
Private Payer	23,079	58.4%
TOTAL	39,547	100.0%

California General Hospital Discharge File 1997, analysis by SGR Health.

Expenditures by Payor Source and Expenditures Over Time

Tables 3-5 4 below give us one more view of funding sources and expenditures in a national perspective, as well as how expenditures have changed over time. What is notable is the following in 1998:

- California's expenditures in total were more than those for any other state except for New York ($537, 235,700 as opposed to New York's $794,325,036). Moreover, New York has fewer residents than California.
- California's funds were from its state alcohol and drug agency/other state agencies (such as corrections), from its federal SAPT block grant, which was the largest in the country, other federal support, from county and local agencies, and other sources (now including programs such as CALWORKS, which is spending an estimated $60 million on such treatment in 2002)
- California's total expenditures fluctuated between a low of $488,578,000 in 1996 to a high of $537,235,700 in 1998 (Table 3)
- Between 1993 and 1998 California's expenditures rose a slight 7%, while our population and reported use of drugs and alcohol by youth and adults increased substantially (Table 5 below)

Table 3

Expenditures Reported for State Supported Alcohol and Other Drug Services By State and Funding Source For Fiscal Year 1998[ii]

State	State Alcohol & Other Drug Agency	Other State Agency	SAPT Block Grant	Other Federal Government	County or Local Agencies	Other Sources	TOTAL
Alabama*	3,513,163	0	20,345,880	851,370	0	0	$ 24,710,413
Alaska	17,863,196	0	1,966,493	5,425,654	0	0	$ 25,255,343
Arizona	20,763,796	1,000,000	26,160,912	5,147,654	2,084,871	0	$ 55,157,233
Arkansas*	5,364,969	0	9,376,160	2,926,550	287,733	0	$ 17,955,412
California*	0	128,218,700	206,543,800	23,982,400	48,927,700	129,563,100	$ 537,235,700

Colorado	7,889,550	5,804,973	19,241,032	5,916,835	7,289,986	11,908,450	$ 58,050,826
Connecticut*	69,666,443	8,991,518	14,724,891	6,223,240	1,548,811	35,976,979	$ 137,131,882
Delaware	9,804,768	86,225	4,570,192	490,350	0	0	$ 14,951,535
Florida	59,434,456	22,000,000	52,500,324	32,731,387	57,200,296	8,230,278	$ 232,096,741
Georgia	36,569,869	0	29,080,718	2,175,878	0	0	$ 67,826,465
Hawaii	6,282,126	0	6,075,811	0	0	0	$ 12,357,937
Illinois*	86,335,651	0	55,238,111	9,166,552	297,541	21,415,929	$ 172,453,784
Indiana	7,569,196	6,064,434	27,439,873	5,981,936	231,111	2,536,646	$ 49,823,196
Iowa	9,721,819	0	12,730,659	1,622,835	0	0	$ 24,075,313
Kansas*	4,461,391	0	10,965,077	3,561,041	4,094,232	0	$ 23,081,741
Kentucky	9,023,197	2,026,781	15,814,254	1,723,591	0	0	$ 28,587,823
Louisiana	12,966,153	526,899	25,410,749	4,179,258	0	344,949	$ 43,428,008
Maine	7,880,414	0	5,066,439	3,591,731	0	0	$ 16,538,584
Maryland	34,530,465	0	27,869,194	1,142,709	1,572,059	4,348,951	$ 69,463,378
Massachusetts		0	30,411,000	4,340,000	0	0	$ 82,087,000
Michigan*	29,743,369	1,006,788	51,741,069	5,915,220	9,192,141	15,711,229	$ 113,309,816
Mississippi	3,490,823	538,897	11,250,304	1,061,770	0	0	$ 16,341,794
Missouri*	22,585,759	7,771,904	18,943,862	5,484,289	0	6,192,674	$ 60,978,488
Nebraska*	5,225,119	0	6,389,254	456,414	739,446	2,562,038	$ 15,372,271
Nevada*	3,225,498	0	7,504,205	1,123,623	0	0	$ 11,853,326
New Hampshire		0	5,845,777	543,969	0	0	$ 9,286,402
New Jersey	34,816,672	3,566,515	39,960,635	7,202,626	2,704,547	13,854,868	$ 102,105,863
New Mexico	8,895,138	0	6,779,047	669,500	0	0	$ 16,343,685
New York	310,759,398	0	76,069,912	15,296,392	55,294,648	336,904,686	$ 794,325,036
North Carolina*		0	27,972,591	10,552,702	0	0	$ 87,755,151
North Dakota	0	4,521,033	2,318,047	512,729	0	430,181	$ 7,781,990
Ohio	34,013,066	0	58,013,875	21,515,561	71,801,919	62,562,647	$ 247,907,068
Oklahoma	10,185,806	601,949	14,589,554	1,453,940	0	0	$ 26,831,249
Oregon	13,592,629	48,991,762	13,055,199	4,468,955	3,525,354	0	$ 83,633,899
Pennsylvania	37,175,222	62,158,305	49,141,397	3,313,355	6,162,057	8,808,866	$ 166,759,202

Rhode Island*	14,470,433	0	4,167,827	2,046,251	0	0	$ 20,684,511
South Carolina		222,035	14,742,994	1,643,719	0	0	$ 21,461,764
South Dakota	2,506,266	0	2,268,290	1,498,772	0	0	$ 6,273,328
Tennessee	8,953,611	0	21,411,878	0	59,900	0	$ 30,425,389
Texas	27,250,890	1,473,897	121,063,515	6,713,584	0	0	$ 156,501,886
Utah	10,263,246	1,171,224	10,267,418	7,269,961	3,938,255	6,908,431	$ 39,818,535
Vermont	4,278,306	0	2,425,285	2,560,141	0	0	$ 9,263,732
Virginia	31,533,487	0	34,040,483	3,779,695	20,617,724	10,080,552	$ 100,051,941
Washington	37,229,528	15,499,991	20,399,490	17,617,140	395,719	0	$ 91,141,868
West Virginia	5,950,886	0	7,720,390	500,424	0	0	$ 14,171,700
Wisconsin	33,932,352	4,357,500	23,362,600	8,324,000	0	3,828,000	$ 73,804,452
TOTAL	$ 1,204,033,656	$326,601,330	$1,252,976,467	$ 252,705,703	$ 297,966,050	$682,169,454	$4,016,452,660
% of Total	30%	8%	31%	6%	7%	17%	100%

Funding Flow, Funding Silos and Payor Mix

The use of the term “state-funded” programs is somewhat confusing because in California that state appropriates some of the expenditures we have seen, while others are contributed by the federal government through the block grant or other grant mechanisms, and still others by the counties, cities, or state agencies other than DADP. In the area of substance abuse spending, a large proportion of funding spent by the states originates in the federal block grants, which flow from the federal Center for Substance

Abuse Treatment to the State, which then distributes these federal funds to the counties, along with spending other state appropriations such as those from the General Fund for prevention and treatment. While the SAPT block grant funds from the federal government may be substantial, and managed by the State, the State does not have complete discretion to spend these funds as it wishes. The block grant requires that the State maintain a certain level of its own spending in order to qualify for the block grant funds and reduces federal funds by a dollar for each dollar the state reduces its contribution (called the Maintenance of Effort requirement). In addition, block grant funds can be earmarked by the federal or State government for special populations such as children with alcohol and substance abuse problems, pregnant addicted women and other groups with rising need and poor access to services. Other funds, such as the $120 million appropriated for drug treatment services under Proposition 36 or other voter initiatives may also be earmarked. Therefore, the State-funded treatment system may have many payors to manage and satisfy, each with its own requirements, and it may have very restricted discretion in how the funds it manages can be spent at the state or county levels.

Funding Silos May Not Suit Client Needs

Substance abuse funding, like mental health or criminal justice funding, comes from many payors and government agencies. As noted above, many of these agencies have categorical funding and eligibility requirements, in addition to specifying how and for whom funds may be used and some also require that they be used in complete isolation from other funds. Such funding "silos" are created by legislative requirements, not by the clinical and social needs of drug and alcohol treatment clients. A person dependent on alcohol and/or drugs has many needs that require services to be blended or "braided" as addiction psychiatrist Kenneth Minkoff, M.D., has noted in his training sessions on integrating primary care and drug and alcohol treatment. Most alcohol and drug dependent individuals require medical monitoring for medical/primary care problems, as well as treatment for dependence on alcohol and/or drugs. However, public primary care funding, also in categorical silos, comes from different federal and state agencies than alcohol and drugs funds and may be difficult for alcohol and drug treatment providers to access on behalf of a patient. In addition, alcohol and drug dependent individuals may need vocational rehabilitation, income assistance and social services, family counseling, housing in this costly state, educational assistance or tutoring, or other specialized services for juveniles. Drug or alcohol dependent individuals who are incarcerated have an additional set of issues and an additional set of siloed funders who dispense the services they need. Drawing all of these services together into a coherent whole is one of the goals of such innovations as the "systems of care" recently implemented for mentally ill children and some adults in California (The May 2002 Governor's budget revise proposes elimination of funding for these systems). Such systems of care, while appearing to be an excellent mechanism for blending or braiding funds that cross categorical silos, often falter because individuals involved or agencies for which they work are unable to work out legal, categorical funding or political disputes sufficiently well, sufficiently quickly or in sufficient numbers to make good decisions on behalf of the recovering clients. There is no obvious answer to the question of how to resolve and "braid" the obvious funding silos that confront the state on behalf of its alcohol and drug

treatment clients, especially in a state where public treatment funding for alcohol, drug and mental health treatment is declining while the need and the population are growing.

In this state, unlike some others shown in Tables 3-5, the counties and cities raise their own additional funds, as well as receiving state funds and state-supplied federal funds, with which to assist alcohol and drug clients. California is somewhat unusual both in the level of its county and local contributions to funding and in the size of its federal block grant. No matter whether the percentage contribution to total funding is small or large, the funds are greatly needed and the waiting lists of those who would like to benefit from them are long:

Table 4 below shows the amounts and types of spending by payor for California. :

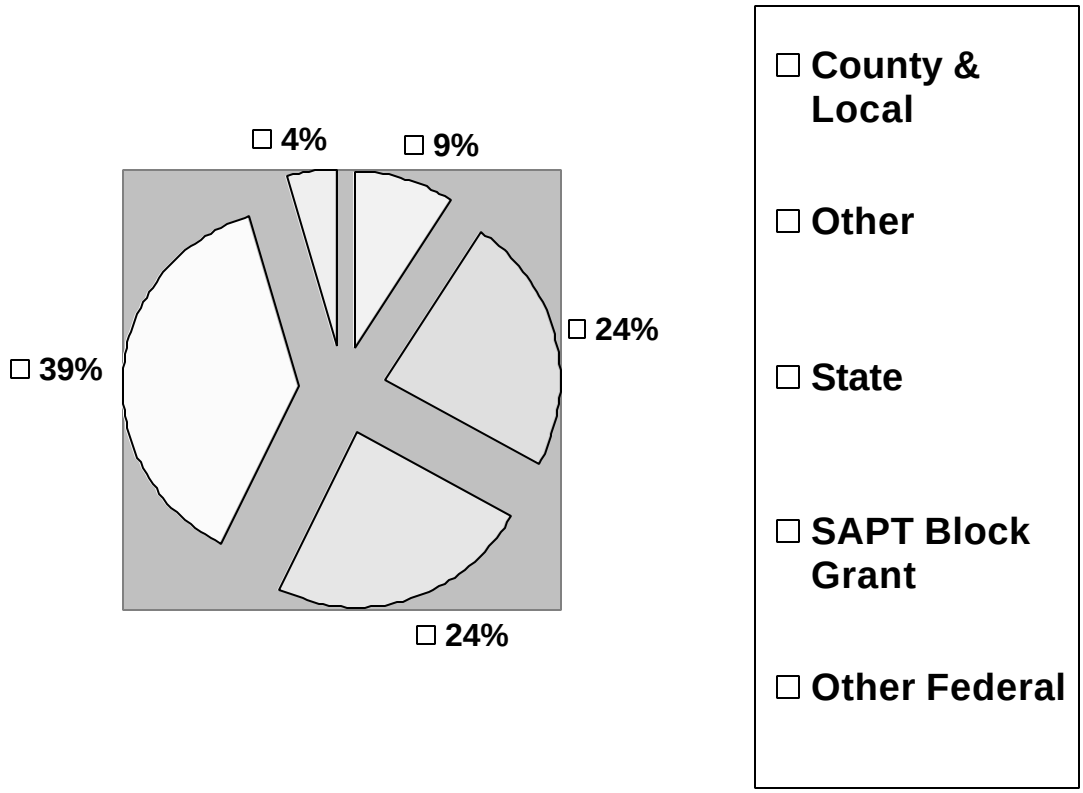

Table 4

Amount and % of Specialty Substance Abuse Spending by Type – CA 1998[iii]

SAPT Block Grant	$206,543,800	39%
Other	$129,563,100	24%
Other State	$128,218,700	24%
County and Local	$48,927,700	9%
Other Federal	$23,982,400	4%
TOTAL	$537,235,700	100%

Table 5

Expenditures Reported for State-Supported Alcohol and Other Drug Services By State, For Fiscal Years 1993, 1994, 1995, 1996, 1997, and 1998[iv]

State	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	93-98% Change
Alabama	18,065,495	19,023,249	22,694,860	21,460,890	25,407,964	24,710,413	37%
Alaska	28,088,225	36,195,602	22,450,175	25,462,400	28,097,100	25,255,343	-10%
Arizona	32,838,245	34,355,626	32,458,699	35,919,191	38,280,597	55,157,233	68%
Arkansas	11,238,381	14,508,228	15,264,992	16,425,607	18,489,899	17,955,412	60%
California	500,943,954	497,300,749	544,851,000	488,578,000	507,437,000	537,235,700	7%
Colorado	44,279,464	47,139,474	51,124,582	54,817,004	58,504,360	58,050,826	31%
Connecticut	92,837,713	96,250,561	102,525,662	112,606,516	125,667,292	137,131,882	48%
Delaware	7,180,556	8,566,793	8,887,347	8,747,229	11,633,740	14,951,535	108%
Florida	147,674,947	176,570,401	192,020,229	270,485,154	271,428,774	232,096,741	57%
Georgia	69,606,260	68,907,815	69,501,022	71,537,558	75,936,993	67,826,465	-3%
Hawaii	14,603,823	15,600,241	17,841,224	19,253,214	20,502,912	12,357,937	-15%
Illinois	147,117,555	157,081,696	204,960,979	179,910,878	175,355,857	172,453,784	17%
Indiana	46,636,000	50,404,320	52,527,820	50,998,685	52,781,285	49,823,196	7%
Iowa	34,965,359	37,568,384	50,111,156	46,279,950	44,905,196	24,075,313	-31%
Kansas	14,631,292	19,258,824	18,156,687	23,299,015	19,035,918	23,081,741	58%
Kentucky	24,549,699	25,309,375	25,715,370	23,765,475	25,915,027	28,587,823	16%
Louisiana	30,362,624	30,240,877	34,964,571	26,052,371	41,533,151	43,428,008	43%
Maine	10,798,553	12,894,225	15,232,636	14,634,002	14,291,566	16,538,584	53%
Maryland	78,812,460	74,057,516	76,283,076	74,660,373	76,365,798	69,463,378	-12%
Massachusetts	71,421,389	69,047,028	76,212,460	77,088,000	77,088,000	82,087,000	15%
Michigan	138,369,618	132,413,415	151,573,606	129,304,361	137,694,562	113,309,816	-18%
Mississippi	11,019,744	13,754,550	14,915,278	15,308,988	16,592,739	16,341,794	48%

Missouri	43,948,561	49,765,048	44,744,508	55,734,389	55,683,450	60,978,488	39%
Nebraska	13,715,995	14,280,757	15,085,068	15,237,995	15,283,912	15,372,271	12%
Nevada	10,096,652	10,080,810	10,564,331	10,422,191	10,773,800	11,853,326	17%
New Hampshire	5,282,449	5,974,767	7,290,076	8,568,567	8,329,052	9,286,402	76%
New Jersey	85,449,000	97,353,825	102,089,567	93,615,158	95,434,406	102,105,863	19%
New Mexico	15,677,542	13,398,412	23,833,597	13,949,708	14,258,058	16,343,685	4%
New York	760,185,867	842,813,913	840,056,882	891,374,902	789,129,988	794,325,036	4%
North Carolina	53,052,660	60,497,245	60,466,422	67,101,622	67,852,682	87,755,151	65%
North Dakota	4,084,000	4,268,000	4,213,000	5,452,212	4,730,557	7,781,990	91%
Ohio	140,371,415	168,083,351	177,308,445	192,364,274	192,364,274	247,907,068	77%
Oklahoma	22,392,837	23,825,158	23,480,541	25,708,898	24,387,599	26,831,249	20%
Oregon	73,458,228	78,179,752	82,778,742	81,440,523	85,170,703	83,633,899	14%
Pennsylvania	139,904,395	185,024,436	223,120,406	120,440,334	147,412,010	166,759,202	19%
Rhode Island	23,111,047	23,726,000	24,044,163	22,835,562	21,637,808	20,684,511	-10%
South Carolina	44,527,001	52,380,244	45,362,123	34,748,791	34,723,852	21,461,764	-52%
South Dakota	13,067,239	13,250,974	12,892,649	8,070,037	7,656,092	6,273,328	-52%
Tennessee	29,025,397	29,182,498	28,812,282	28,812,283	29,082,929	30,425,389	5%
Texas	126,393,813	147,603,178	174,713,730	92,598,790	112,505,607	156,501,886	24%
Utah	26,288,652	31,621,948	36,816,506	33,255,224	39,308,084	39,818,535	51%
Vermont	6,768,140	6,619,724	7,542,924	7,985,455	7,444,830	9,263,732	37%
Virginia	73,444,483	84,508,710	89,194,350	85,716,359	90,932,666	100,051,941	36%
Washington	70,778,272	75,684,709	72,165,460	76,147,989	85,679,708	91,141,868	29%
West Virginia	11,670,728	12,501,779	17,350,261	18,939,874	27,575,707	14,171,700	21%
Wisconsin*	148,144,800	144,257,600	59,067,626	122,229,100	123,531,584	73,804,452	-50%
TOTAL*	$ 3,516,880,529	$ 3,811,331,787	$ 3,983,267,090	$ 3,899,345,098	$ 3,953,835,088	$ 4,016,452,660	14.20%

Wisconsin notes that in '93, '94, '96, '97, expenditures reported erroneously included all State expenditures for substance abuse treatment, and not only those programs that received at least some funds administered by the State Alcohol and Other Drug Agency.

Effects of Avoidable or Unavoidable Funding Variation on System Predictability and Manageability

Funding variations by year, such as the ones shown in Table 5, are endemic to the public substance abuse treatment field. Often the only thing that can be expected is that funding levels will change – and, in the near future in California, that they will decline, despite growing need. The impact of what may appear to be unfortunate, arbitrary or politically motivated funding reductions is demoralizing and disorganizing for state and county drug and alcohol agencies and managers, for the treatment providers, for local communities who depend on these funds for services essential to their addicted residents and for the drug and alcohol clients and their families who are clamoring for more services, not less. The inability to predict funding levels, combined with the typical inadequacy of funding compared to need in the alcohol and drug field, creates a stigmatized, demoralized and often less effective and efficient set of services and agencies than this state needs. Predictability is a key to managing a system, to preserving a reasonable and rational budget and attracting and retaining staff in what is at best a difficult enterprise. It is confounded completely when budgets continually rise and fall at every level of government. Managing treatment programs becomes an exercise in survival and in politics, rather than in service improvement and responsiveness to clients and their continuing and emerging needs. While it is important to government that services and agencies be held accountable for their share of scare and needed funds, accountability over continuing insufficiency leads to a stigmatized system that cannot attract or retain the critical staff or resources that it needs to do a decent job. And the downward spiral can be hard to reverse, as other agencies and populations that are better liked or more tractable compete ever more successfully for a share of a declining pie.

California Department of Alcohol and Drug Programs (DADP): 2002 - 2003 Budget Analysis

California's DADP is at the center of the payor and client maelstrom that we have described above. While it is a critical department, it serves a clientele that many politicians wish would disappear. As you have seen above, California has great demand for its state-funded drug and alcohol rehabilitation and prevention services, most of which are provided at the local community level but funded by the state and federal government, managed through the DADP budget. There is a nationally documented drug and alcohol treatment gap in California and the rest of the states that results in people who want to be treated and want to stop being alcohol and drug dependent waiting many months to be admitted to existing public treatment programs (CSAT, National Treatment Plan, 2000). Some estimates indicate that persons desiring to be treated exceed treatment capacity by nearly 100%. It has been far easier to raise funds for drug interdiction in the "war on drugs" than for the public treatment system.

Accumulated research shows that drug and alcohol treatment works in many respects, even for those who drop out of treatment before completion. The recent review by the non-profit Physician Leadership Council on National Drug Policy of more than 600 research studies showed that addiction and alcohol treatment reduce substance abuse, crime, and medical costs, as well reducing personal, family and community misery and tragedy. The 1994 CALDATA study conducted in California by the National Opinion

Research Center analyzed experiences with drug treatment in 1991 and 1992 and concluded that the $200 million spent on treatment during that time yielded a 7:1 return on investment. Although treatment cannot help everyone, it has repeatedly been shown that alcohol and drug treatment systems are a good investment.

While in treatment, often long neglected medical needs of alcohol and drug treatment clients are addressed routinely, rather than on an expensive ER basis or not at all. Clients who are undergoing treatment have less time, motive and opportunity to commit crimes than those who are wandering the streets without treatment. Many are able to complete high school or even college graduation requirements due to treatment and are more successful in finding jobs after treatment. Fewer medical problems, better employment prospects, and better school opportunities help treated clients to improve family and household life, resulting in less expensive medical and psychological problems in their households. Less need to commit crimes to obtain money to buy alcohol or drugs leads to lower community incarceration and court system costs, which we know are substantial in this state. Less intoxication from alcohol and/or drugs also leads to less drunk driving, fewer costly or fatal traffic accidents, and less court involvement and community tragedy in such cases. After drug treatment, clients are less likely to commit or be victims of domestic violence and their households and children benefit from this improvement as well as the clients. Employers and the tax coffers also benefit if treated employees can maintain their recovery and return to their previous jobs, eliminating the need to recruit, hire and train new workers, and guaranteeing that rehabilitated workers feel more loyalty to the firms that hire, rehire, or continue their employment. Employed workers also pay taxes. In every respect, society, the economy, clients, families, the criminal justice system, the courts, the healthcare system, our highways and communities and even tax/welfare rolls benefit greatly from drug and alcohol program investments such as the publicly funded treatment system in California. In this case, however, money must be spent in the short term in order to reap these longer term financial, personal and social improvements.

Drug and alcohol programs at the Federal, state, county, municipal and even employer levels are often viewed as acceptable targets for cost-cutting, in part because of the continuing stigma surrounding alcoholism and drug dependence, regardless of the success of the treatments. This year at the Federal level, however, spending on such treatment through the SAPT block grants is actually increasing by $60 million nationally.

For the 2002-03 budget year, the Governor proposes in his newly revised budget to spend $544 million from all fund sources, a decrease of about $47 million or 8% below the 2001-02 figures, according the Legislative Analyst's Office, and not significantly above the $537 million spent in 1998. This reduction occurs despite the continuing large increase in publicly treated drug offenders that is due to Proposition 36, for which the voters approved a $120 million appropriation for Proposition 36 included in the revised budget. It occurs at the expense of participants in the Drug/Medi-Cal program, which has severely restricted and inadequate benefit coverage for substance abuse, it occurs by putting off indefinitely an expansion of Drug/Medi-Cal day-care rehabilitative services indefinitely. Funding for drug courts and perinatal services has also been proposed for elimination to help address the state's fiscal shortfall.

Significant additional reductions in local assistance for drug/alcohol treatment services are also featured in the Governor's revised budget, in addition to the above noted reductions. The LAO report notes that all of these reductions, taken together, could violate Federal block grant requirements and put additional Federal funds at risk. These proposed reductions occur after $42 million in General Fund reductions for drug and alcohol programs in 2001-02. The LAO says that questions exist as to the effects of the proposed drug court reductions, which it could not opine about definitively because the evaluation of the drug court program has not been delivered yet to the Legislature. The Governor and DADP also expect a promised increased block grant allocation of $15.4 million that could, if received, be used to compensate for some of these budget cuts at either the state or the county levels. However, the state would still not be meeting the Federal maintenance-of-effort requirements under the block grant because the additional funds come from the block grant and not the state. (An MOE waiver is a possibility but not a sure thing; it requires a successful state application and is a rarely used process that the current Federal administration may not be likely to grant to California). Putting already threatened and insufficient funds at risk by reducing state expenditures may be very problematic, in view of the demand for services in alcohol and drug treatment and what happens when people cannot get the treatment they need and want.

The LAO reports also considers that it may be possible to increase state drug and alcohol funding by shifting some asset forfeiture proceeds to local DADP assistance programs. Statutory changes would be required to accomplish this. Other states have taken this step, which does come at the expense of local law enforcement agency budgets, but federal law does allow up to 15% of federal asset forfeiture proceeds to be used for drug treatment programs. The amount raised through this venue is not expected to exceed $4.5 - $10 million, not enough to close the treatment gap or to provide treatment services on demand.

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[i] NASADAD, 2000
[ii] NASADAD, 2000
[iii] NASADAD, 2000
[iv] NASADAD, 2000